The Royal Australian & New Zealand College of Psychiatrists

Submission to the NSW Government

Special Commission of Inquiry into Healthcare Funding

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5. **Recommendations**
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1. Acknowledgement of Country

We acknowledge Aboriginal and Torres Strait Islander Peoples as the First Nations and the Traditional Owners and Custodians of the lands and waters now known as Australia. We recognise and value the traditional knowledge held by Aboriginal and Torres Strait Islander Peoples and honour and respect the Elders past and present, who weave their wisdom into all realms of life – spiritual, cultural, social, emotional, and physical.

1.1 Acknowledgement of Lived Experience

We recognise those with lived and living experience of a mental health condition, including community members and RANZCP members. We affirm their ongoing contribution to the improvement of mental healthcare for all people.

2. About the Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrist (RANZCP) is the principal organisation representing the medical specialty of psychiatry in Australia and New Zealand providing access to Fellowship of the College to medical practitioners. The RANZCP has approximately 8000 members bi-nationally. The NSW Branch represents over 2000 members, including over 1400 qualified psychiatrists.

The NSW Branch offers a substantial resource of distinguished experts – academics, researchers, clinicians, and leaders dedicated to developing expertise in understanding the risk factors of mental disorders, treating individuals and families, developing models of care and promoting public health measures that will reduce the personal suffering, loss of potential and huge economic costs caused by mental disorders in our community.

3. Introduction

Nationally, New South Wales (NSW) has slipped to the bottom of mental health spending and service delivery (1).

Due to successive governments neglecting to appropriately plan and invest in mental health, we now have a system where:

- per-capita spending on all mental health services in NSW is lower than all the other states and territories
- per-capita expenditure on community mental health services in NSW is at the same level as it was in 2016-17
- NSW spends $50 less per person on community mental health services than WA, the highest spending state (2)
- NSW spends a higher proportion of the mental health budget on inpatient services than any other state, yet
- between 2011-12 and 2020-21 the number of specialised mental health hospital beds has reduced from 36.5 to 33.3 per 100,000 population and residential mental health service beds have reduced from 2.4 to 0.4 per 100,000 population (3).

Not only is the current level of funding for mental health services in NSW grossly inadequate, and the system plagued by lack of planning and fragmentation, but much of any new funding is often short-term, project based and not informed by local need and knowledge.

The range of services delivered by NSW Health community mental health services has narrowed to such an extent that it services just two core populations:

- those with severe chronic mental illness requiring ongoing care under the Mental Health Act (Community Treatment Orders) and
- those requiring crisis follow-up after emergency department (ED) presentations.

There are services for Child and Adolescent (including the recent Safeguards investment), Youth, and Older Persons and Forensic mental health services, and other tertiary referral services but these are generally narrow in focus, feature tight inclusion criteria, and take no responsibility for those who do not meet criteria.

This submission has been informed by psychiatrists on the frontline of mental health service delivery across the state, who have described the inconsistencies they experience in service delivery and governance across LHDs (1). The problems caused by these inconsistencies are compounded by a reduced willingness of LHDs and NSW Health to engage specialists in decisions that

influence their ability to treat their patients (4). This unintended or otherwise sidelining of psychiatry is a factor in the major psychiatric workforce crisis affecting this State.

Psychiatrists have also described how chronic underinvestment in the sector's workforce, and the failure to resource community mental health services have depleted the system to such an extent that hospital emergency departments (EDs) have become the main entry point into the mental health system for many people (5).

The RANZCP position statement on principles for mental health systems identifies the key principles of optimal mental health systems as:

- Equitable access
- Culturally safe
- Skilled, well-resourced workforce and clinical leadership
- Partnering with people with a lived experience
- Supported decision making
- Trauma-informed practice
- Responsive, compassionate, person-centred care
- Integrated policies, systems, and services
- Evidence-based systems, services, and practices
- Consistent, coordinated data collection
- Research, evaluation, and quality improvement

The RANZCP continues to strongly advocate for realistic and innovative funding strategies to bridge the serious gaps, delivered in the context of governance and structural reform, with the aim of accessible, efficient, and integrated service delivery (4).

The RANZCP also notes that the funding of mental health services means funding the right workforce, not only in terms of numbers, but skill mix. Attracting, training and retaining the right workforce will require a commitment to rolling out a suite of strategies, not in a 'business-as-usual' way, but by a dedicated MH taskforce or unit.

4. The RANZCP's responses to the Special Commission's terms of reference

A: The funding of health services provided in NSW and how the funding can most effectively support the safe delivery of high quality, timely, equitable and accessible patient-centred care and health services to the people of NSW, now and into the future

- **How it is provided**

Mental Health services in NSW are under-resourced and do not meet the needs of the population. Major investment is required to, at least, bring mental health funding in NSW up to the levels of other states. The specific level required remains unknown. Little formal system planning has been undertaken to determine the quantum required

to reach appropriate service levels. The National Mental Health Service Planning Framework is one tool that determines the service levels and resources required to meet the needs of specific populations.

We welcome the NSW Government's decision to use it and other tools to provide a Gap Analysis in 2024. Given the experience of other States, the investment required to close the identified gaps is going to be considerable, and not able to be funded by traditional Treasury enhancements. For example, Victoria and Queensland have recently implemented a payroll tax surcharge on businesses (with payrolls in excess of $10 million per annum) to fund expansion and reform of mental health services, as a consequence of major reviews of their systems.

In NSW, mental health budgets have been vulnerable to exploitation by LHDs through using mental health budgets to fill gaps in other parts of the health system. Examples include delaying recruitment, delaying commissioning of funded services, and using yet to be spent mental health funds to balance the books in other parts of the service. This has obviously had a deleterious impact on mental health service delivery and must be stopped.

The RANZCP notes the pending review of the NSW Mental Health Commission. The view of the RANZCP is, that despite good intentions and investment in the Commission, it is not clear it has had a significant impact on mental health service quality and delivery over the last decade.

By the most important measures for consumers, which is, being able to access timely assessment, in the most appropriate setting, and then be delivered evidence-based care – things are going backwards (1,2). This review poses an opportunity to define the role of the Commission into the future, including the extent of the monitoring role for MH Service performance and funding, and defining what actions it can take in circumstances of poor performance and non-compliance. There is also the opportunity to explore expanded roles for the Commission, for example more of a fund-holding role, as occurs with the Western Australian Commission.

RANZCP members are calling for a commitment to major investment in MH in NSW, using innovative funding solutions. After the 2024 Gap Analysis we need a commitment to clearly define and quarantine mental health budgets within each LHD and a dedicated 'Mental Health Workforce Unit' to be administered by the Ministry of Health with the involvement of all stakeholders.

- **Effective Care**

Effective care is only possible in appropriately funded, organised, and staffed services. This is a common refrain in this submission, but the reason is obvious. The current system does not allow for provision of holistic care. Holistic care in mental health is effective care. The NSW mental health care system on the brink: Evidence from the

frontline report (1) and other reports (6) citing evidence from the coalface tell the story, but other specific examples, include:

- **Emergency Departments**

Community treatment should be the mainstay of treatment with emergency departments serving as the interface between community and inpatient services. Currently, there is an over reliance on EDs as de-facto mental health clinics, where patients go to seek mental health care, only to experience lengthy waits to be seen by doctors and other clinicians, in settings that are busy, over-stimulating and possibly traumatising.

There is a limited evidence base to support this current 'model of care'. It is the RANZCP position that the ED is the default option for mental health care, due to an overwhelmed and under-resourced community mental health system. We note that EDs are here to stay as providers of mental health assessment and treatment locations, but there needs to be an active exploration of, and research into, the best models that see streamlined and appropriate care provided to mental health patients.

- **Vulnerable populations**

Most mental health populations are vulnerable in the current, under-resourced system. But rural populations suffer more than most due to lack of access to trained clinicians and support services. This is well-documented in the Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales (7).

There are a number of specific populations that are also vulnerable, including Aboriginal and Torres Strait Islander people and communities and culturally and linguistically diverse (CALD) people and communities, due to specific and complex biopsychosocial issues.

Early and late life populations are also at risk of missing out on basic service delivery due to lack of funding for specialised services, shortages of critical staff, and lack of integration with other clinical and support services. Prevention, using early in life intervention strategies**,** instead of early in illness, would represent a significant long-term benefit to the mental health budget and a return on investment in young families and children aged 0-5 and 6-12yrs. Current research and literature identifies that at least 50% of adult mental illness starts under the age of 14yrs.

And for Older Persons, the RANZCP recognises the importance of psychiatry services for older people and has repeatedly recommended to the NSW Government a funding model for old age community teams. Mental healthcare for older people should not be subsumed into a broader 'adult mental health', it should reflect the distinct needs of older people who require care from appropriately trained clinicians with specialised skills.

B: The existing governance and accountability structure of NSW Health

In 2020, The Productivity Commission Inquiry Report into Mental Health (8) recommended regional governance of mental health services, including changes to funding that would see integration of funding from State and Federal funding pools, with improved governance arrangements, for quarantined mental health funding. Similarly, this has been explored, in a co-commissioning model, by NSW Health in a regional model (7).

The NSW Branch of the RANZCP has advocated for scoping of pooled funding and governance arrangements. This would include piloting of Regional Commissioning Authorities, or regional co-commissioning arrangements, funded by pooled Federal and state funds to meet the specific needs of each jurisdiction.

The centralised models create the opportunity for integrated triage and assessment pathways, simplifying the navigation of mental health services, reducing inefficiencies created by multiple mental health silos, that have their own entry points. We also favour service development informed by local evidence and local need. Any such arrangements would need oversight by a strengthened Mental Health Branch within the Department, and/or a strengthened Mental Health Commission.

i: the balance between central oversight and locally devolved decision making (including the current operating model of Local Health Districts)

There is a clear sense that there is no one 'pulling the levers' in NSW Mental Health. The Ministry provides a policy role but has no operational responsibility. Devolution of responsibility to LHD Boards and Chief Executives has led to inconsistencies in service delivery and clinical and operational governance across the State's Mental Health Services.

Workforce issues, including recruitment, are devolved, with poor data sets informing planning, inconsistency in the application of awards, LHDs designing remuneration packages ending up in bidding wars between LHDs, and no sense that there is a Statewide workforce strategy. There also appears a lack of accountability at the LHD level for implementation of NSW Health policies.

Our psychiatrists report that the current operating model in LHDs is hospital centric, fragmented and siloed with disparate intake criteria, no consistency of journey mapping nor continuity of care. We've also seen how short term funded programs have a destabilising effect on mental health services in NSW (4) - staff leaving permanent roles for project roles, which has a destabilising effect on the already vulnerable workforce and clinical teams.

The balance between central and local governance doesn't seem right, and without any clear central review of oversight mechanisms LHDs are open to poor management decisions with respect to mental health service delivery.

As a recent example, one LHD was provided funding from the Department for senior nursing clinicians in mental health, but a local decision was made for those nursing clinicians to be used solely for the provision of physical health assessments and care planning for older people with mental illness. This decision was made at a time when mental health services were overwhelmed and did not have enough staff to do timely acute assessments. Another LHD used Covid-funded increased psychiatry hours in their older persons team for peer workers.

The Safeguards program, an innovative program for child and adolescent mental health and the most significant child and adolescent investment ever in NSW, has suffered similar issues, with the fidelity of the model impacted by local issues and biases. There are also difficulties with getting actual data on the performance of the program because LHDs have structured the program differently, some incorporating them within existing Child and Adolescent Mental Health Services (CAMHS) teams, within different cost centres (contaminating performance and activity data).

There does not seem to be a mechanism for accountability for such decisions. Improved Departmental or central governance is required to ensure that LHDs deliver what they are funded to do.

The solution is difficult given the current structure and legislation, but other jurisdictions have used an Inspector General model, with powers to inspect, investigate and direct services, who have been found straying from their remit. A re-considered Mental Health Commission could have such a role.

ii: the engagement and involvement of local communities in health service development and delivery

The RANZCP supports partnering with local communities and those who have a lived experience in the co-design of mental health services. We need to view ourselves as part of the community ecosystem. We seek to overcome cognitive bias when designing services and respect the opinions of patients, families, and carers.

All services would benefit greatly from involving the community in the development and delivery of mental health services. This would include full exploration of community solutions to meeting their identified needs.

That said, the RANZCP believes that there are core services that are the right of all the people of NSW to have access to. There is no wriggle room about core service deliverables, and these should be clearly defined by NSW Health, but there is the need for local engagement in the ‘how’ those deliverables are specifically met given local population variance.

iii: how governance structures can support an efficient implementation of state-wide reform programs and a balance of system and local level needs and priorities:

As noted above, there is a desperate need in NSW for wholesale reform of the mental health system, within Health and beyond. Governance structures which deliver integration are the obvious fix to a fragmented and un-navigable system. The RANZCP believes that attempts at simple cooperation between services can achieve only so much, and that the fragmented system can only be integrated via new governance arrangements (e.g., via co-commissioning or regional authorities) leading to a system that is more efficiently resourced, navigable, accessible, and, hopefully, more equitable.

On the question of rolling out other NSW Health reforms, again, there is the issue of devolution of power to the LHD's, and the difficulties keeping LHD's accountable for not delivering such reforms. Mental health has a history of State-wide reforms not being rolled out consistently across the State, due to local 'priorities.' Only with an increased capacity of the Mental Health Branch or Mental Health Commission to monitor and direct, will we see consistent delivery of what is promised.

iv: the impact of privatisation and outsourcing on the delivery of health services and health outcomes to the people of NSW

There is limited formal outsourcing to the private sector in NSW. Some LHDs have arrangements with private hospitals for overflow, and some specific inpatient and outpatient projects via private hospitals have been funded (mostly Covid funding) but are unlikely to receive ongoing funding.

NSW Health also funded headspace centres ($20 million, ending June 2025) to deliver services to youth in the context of the dramatic rise in child and youth presentation rates during Covid. headspace (Federally funded via PHNs) was considered the only viable scaling up option in the youth sector, and NSW Health then directed funds to increase the capacity of headspaces to deal with the increased complexity and volumes of young people seeking help (mainly presenting via EDs).

The funds provided contracted psychiatry and general practitioner (GP) time, as well as clinical educators to provide supervision to allied health staff (clinical psychology, occupational therapy, and social work student placements), across the 35 NSW headspace sites. It is an exemplar of how State and Federal funding arrangements can be married to deliver essential care, and a potential model for other State/Federal integration opportunities, with the role out of other Federal streams like the Mental Health Medicare Centres.

v: how governance structures can support a sustainable workforce and delivery of high quality, timely, equitable and accessible patient-centred care to improve the health of the NSW population

NSW Health either lacks, or chooses not to exercise, the kind of governance influence over the LHD's that is needed to consistently support a sustainable workforce. Basic psychiatrist position descriptors, such as access to time to participate in supervision, teaching, research, quality improvement, and clinical leadership are being eroded and there is a commonly held perception that engagement of psychiatrists in clinical governance and leadership is not a priority for the mental health system.

We have had recent decisions in two Sydney LHDs where psychiatrists are excluded from applying for Mental Health Executive Director positions. There is a proud tradition of quality mental health service leadership by psychiatrists in this State and this is now under threat. The advice from our membership is that, increasingly, decisions are being made by management, some without any clinical background, disconnected from the reality of service provision. Consequently, psychiatrists report feeling under-valued, disrespected, and excluded from input into decisions that affect them and patient care (1, 8). Including the specialist workforce in service leadership, development and policy implementation would improve staff retention, and make psychiatry a more attractive specialty for young doctors. According to Baker, Beck Geerts, Goodall et al 2020 (9), having doctors in leadership roles in hospitals is known to have positive outcomes for patient care and organisational performance, further confirmed by American and United Kingdom studies which found that the best performing hospitals were those with a high proportion of managers with clinical degrees (10).

A recent RANZCP (May 2024) survey of NSW Health psychiatrists and trainees (with 75% response rate) found that our senior trainees are looking at the next stage of their careers being outside the public sector, and that 70% of staff specialists are looking to leave the system in the next 12 months.

Following the recent release of Australian Bureau of Statistics (ABS) data showing that one in five Australians experienced a mental health disorder, The RANZCP issued a media release calling for immediate action to combat Australia's severe psychiatry workforce shortage.

RANZCP's February 2024, Burnout and moral injury: Australian psychiatry at its limits report (11) specifically reported on burn-out affecting the psychiatric sector.

The report found that:

- 9 in 10 psychiatrists said the current workforce shortages negatively impact patient care
- 7 in 10 psychiatrists reported experiencing symptoms of burnout in the past three years, and

- 82 per cent of Australian psychiatrists cited workforce shortages as the top factor contributing to so many psychiatrists experiencing the symptoms of burnout.

In NSW, the psychiatry workforce is under extreme pressure and unable to meet the needs of consumers. In some areas services are either non-existent, or the criterion for eligibility has increasingly tightened due to workforce issues. Staff recruitment and retention is becoming increasingly difficult across all services, in all areas, but especially so in regional and rural communities. The quality and quantum of care able to be delivered is under threat due to a shrinking and demoralised clinical workforce.

At a district level, governance is reasonably clear within the LHD, with psychiatric staff identifying with their clinical stream, and this has been strengthened in recent years by the development of Mental Health Medical Staff Councils, providing direct access to the local Boards and Chief Executives. That said, the broader governance issues noted above have ongoing negative impacts on the care that can be provided to consumers.

Beyond the LHD, there are also the broader governance challenges, notably those at the interface between State funded services and those delivered under Medicare and other Federally funded services. Opacity around which level of government is responsible for what service provision creates more gaps for people to fall through.

NSW Health, mainly via the Mental Health Branch and Workforce Branch, has recently reinvigorated the NSW Psychiatry Workforce Plan, in response to sustained pressure from the RANZCP and industrial bodies about the nature and scale of the workforce crisis affecting the State.

This aims to address issues beyond salaries and conditions (remuneration for staff specialists and Junior Medical Officers (JMOs) being the lowest of all States and Territories), including innovative rostering models, scoping a Statewide on-call service (noting on-call demands being a major cause of burn-out and stress for current staff specialists), and improved access to study leave. The RANZCP is committed to being engaged with this planning exercise, as long as it delivers targets and strategies to meet them.

C: The way NSW Health funds health services delivered in public hospitals and community settings, and the extent to which this allocation of resources supports or obstructs access to preventative and community health initiatives and overall optimal health outcomes for all people across NSW

The RANZCP 'Mental Health for the community' position statement says that community mental health services should be seen as an array of primary and

specialist, government, non-government, and private services delivered in a community setting. In an ideal world, specialist community mental health services can be conceptualised as one component of an integrated system of mental care.

But the reality is that NSW government funded community mental health care services and hospital based ambulatory care services have deteriorated to such an extent that they are now inaccessible to many people with a mental health condition. NSW, as a proportion of the mental health budget, spends more on hospital services than any other State or Territory.

Chronic underinvestment has depleted the system to such an extent that hospital emergency departments (EDs) have become the main entry point into the mental health system for many people (5).

- Since 2020, Sydney Local Health District hospitals have experienced a greater than 10% increase in mental health related ED presentations (12).
- And to June 2023, there was a 7% increase in all NSW mental health ED presentations compared to the same time in 2022.
- ED presentations per 10,000 of population in NSW have risen from 87.7 in 2004-5 to 114 in 2021-2022 (13). A high proportion of those patients were delivered into hospital by ambulance (49%) or Police (6%) for lack of an alternative or appropriate mental health service to direct them to (14).
- The proportion of arrivals via ambulance or police to NSW EDs is higher than the national proportion and double the proportion of all presentation to EDs by ambulance or police (14).

Of the people with a mental health condition who present to EDs in crisis, it is only the most acute cases who get a hospital bed. Patients who aren't acute enough for hospitalisation are sent home, most often with instructions to see a GP for a referral to a psychiatrist, or psychologist, that they often can't afford, or can't otherwise access due to closed books or long waiting lists (15).

In community mental health services, case managers (nursing and allied health professionals) are often managing caseloads of up to 40 individual patients. This results in clinician burnout, high staff turnover and more frequent patient presentations to hospital.

This underinvestment in community mental health is seen as the major factor in the mental health access crisis in this State.

D: Strategies available to NSW Health to address escalating costs, limit wastage, minimise overservicing and identify gaps or areas of improvement in financial management and proposed recommendations to enhance accountability and efficiency

Waste is endemic in the sector due to fragmentation, noted above. Multiple services, supported by different funding streams, providing poorly defined and articulated services to similar groups, with multiple intake methods and sites. Real system reform, with integrated governance and funding on the table, is the ONLY way to seriously address service reform.

The system is plagued by attempts at integration via Service Level Agreements, Memoranda of Understanding, leading to endless meetings between services, and buck passing. Integrating Federal and State funded services is the future, and this must be an integral component of the next Federal /State Mental Health Agreement.

A more specific example of inefficiency is the poorly functioning **NSW Mental Health Access Line**. Each LHD Mental Health service runs its own system, some outsource it to a private provider and others use their own staff to manage 24-hour lines of varying quality. Centralising this critical access point would reap major benefits and allow ease of performance measurement. The RANZCP was pleased with the State Government's recent budget announcement aimed as a major fix to this issue via the NSW Mental Health 'Single Front Door Initiative.'

And, as already noted, with a 25% vacancy rate in staff specialist positions in this State, there has been an explosion in locum utilisation, an area of obvious waste.

E: Opportunities to improve NSW Health procurement process and practice, to enhance support for operational decision-making, service planning and delivery of quality and timely health care including consideration of supply chain disruptions

No specific comments beyond the inefficiencies inherent in engagement with multiple providers.

F: The current capacity and capability of the NSW Health workforce to meet the current needs of patients and staff, and its sustainability to meet future demands and deliver efficient, equitable and effective health services, including:

This current capacity is limited and deteriorating due to the crisis in the psychiatric workforce, and the mental health workforce in general. As noted, NSW has a 25% vacancy rate in staff specialist positions, leading to an unprecedented reliance on locum service utilisation to keep services running. This leads to poorer outcomes, generally. Locums can deliver quality clinical services, but do not provide continuity or service/team leadership, affecting patient outcomes and training experiences for registrars.

The lure away from public psychiatry to private practice is decimating psychiatry services in public hospitals. Recruiting into positions in the public system that were once seen as great opportunities to either launch or further a career has become an

increasingly difficult task. It's the case in urban, areas and the challenges are even greater in rural and regional areas.

The RANZCP reports: The NSW mental health care system on the brink: Evidence from the frontline (1) and Burnout and moral injury: Australian psychiatry at its limits (11) detail the factors impacting the psychiatric and broader mental health workforces.

Although there is a reinvigoration of the psychiatric workforce plan, the RANZCP believes a more targeted and resourced entity is required to address the workforce crises across the sector, such as a specific MH Workforce Taskforce or Unit.

i: the distribution of health workers in NSW

The contraction in the psychiatry workforce numbers has occurred against a background of population growth and increased demand, reflected in ED presentations across most LHDs. Things are more perilous out of the major cities, where the level of psychological stress is significantly higher than the NSW average (16), in part reflected by the suicide rates being double the rate of cities (6).

Prior to Covid the mental health system, particularly in outer metro and rural/regional areas, relied on international medical graduates (IMGs) entering the system across the breadth of the State. This came to a standstill during Covid and has not recovered. The Federal Government's recent adoption of the recommendations of the Kruk review, will go some way to seeing more streamlined and timely recruitment of IMGs. The RANZCP aims to assist Government in any way to maintain the standard of IMGs entering the system.

Another factor contributing to the maldistribution, is the lack of incentives for work outside metro areas. Queensland has been at the forefront of offering substantial incentives to work, firstly in the State, then outside metro area, with good results (personal communication)[1].

ii: an examination of existing skills shortages

There is a contraction in clinical variety seen in the public sector services. As described above, the focus of services is provision of care to those with acute psychotic disorders, often with comorbid disorders, and those in crisis. This happens both at hospital and community levels. It results in de-skilling of psychiatrists and limited opportunities for trainees to gain broader clinical experiences. At the end of training, most are ill-equipped to manage the variety of presentations seen in the private system, where most psychiatrists are ultimately headed.

[1] https://www.careers.health.qld.gov.au/working-for-us/workforce-attraction-incentive-scheme#:~:text=Healthcare%20workers%20who%20commence%20working,months%20of%20service%20in%20Queensland.

With appropriate levels of funding for community mental health services, it would be expected that the services would have the capacity to provide treatment to those who have a broader range of conditions.

iii: evaluating financial and non-financial factors impacting on the retention and attraction of staff

This has been discussed in part above. There is a psychiatric workforce crisis. Seventy percent of current specialists say they will leave the public sector in the next 12 months, in the absence of improvements to pay and conditions. As described by one psychiatrist:

> "*Across the mental health workforce there is a perception that trainees and specialists aren't valued; their opinions aren't being listened to or heard; that opportunities for career development aren't there; and they have no influence on service development*."

Remuneration, entitlements, and workplace conditions all need to be reviewed to attract trainees and specialists.

- We have the lowest employment awards for junior medical and senior specialist staff in Australia, specifically non-competitive with our major neighbours in Victoria and Queensland, where specialists are paid up to 25-30% more.
- We have increasing difficulties appointing to staff specialist positions, even at major inner-city hospitals, that were once magnets for junior specialists.
- We have increasing difficulties finding VMO's who want longer-term contracts. These had been desirable, but people are now leaving these arrangements and LHDs are in bidding wars, paying significantly above agreement rates to attract VMOs on short-term contracts.
- We have unprecedentedly high rates of locum utilisation due to the failure to attract permanent staff.
- Training in psychiatry in NSW is less popular than in other States. In NSW, those wanting to enter training in 2024: 135 applicants for about the same number of vacancies; Victoria had 200 applicants for 116 positions; Qld recruitment is robust, believed to be secondary to an up to $70,000 relocation allowance.

- Staff specialists report that they are not able to access existing conditions like non-clinical time, study leave, having little opportunity/time or space to provide supervision, or participate in teaching and research, all at a time when the College is moving to increased focus on workplace-based assessments.
- Our workforce is ageing.
- We have had an exodus of clinical staff, including employed psychiatrists, from the sector post-covid, mostly to the private sector with less stress and significantly greater remuneration.

iv: existing employment standards

As discussed, in the current, overwhelmed system, there is less opportunity to access study leave, non-clinical time for supervision, teaching, research, and other long- and well-established staff entitlements. There is also the commonly held perception that clinical engagement and leadership have become lesser priorities and increasingly, critical clinical decisions are being made by staff who are not clinicians.

v: the role and scope of workforce accreditation and registration

The College accredits training positions and monitors their performance. There are key criteria to be met to ensure the viability and fidelity of the training experience. The College also understands the realities of the current system and stresses, only in the most extreme cases would consider dis-accrediting a training experience and would work closely with government to avoid such a consequence.

vi: the skill mix, distribution and scope of practice of the health workforce

An exodus of staff leads to a loss of expertise across the mental health workforce and across all disciplines, there are struggles to attract and retain staff. For instance, there is a lack of psychiatrists specialising in old age mental health across our workforce, in the EDs, acute units and consultation liaison (CL) teams at a time when our ageing population is one of this State's most critical issues. The same could be said for a number of other sub-specialty areas. There is no easy fix, for example by upskilling other parts of the health workforce, like creating more nurse practitioner positions, because all disciplines face the same workforce crisis.

vii: the use of locums, Visiting Medical Officers, agency staff and other temporary staff arrangements

NSW has high rates of locum utilisation due to the unprecedented haemorrhage of staff specialists form the system. In some LHDs, Locum agencies are advertising vacancies State-wide at rates up to $3,500 a day. Visiting Medical Officers (VMOs) are being paid 10 hours for 8 hours of work.

Over the last decade, due to chronic workforce shortages, LHDs have converted many staff specialist positions to VMO roles. From a budget perspective, one FTE staff specialist position funds only 0.6 of a VMO, so that each time this happens, the State loses 0.4 of a specialist position, further eroding the workforce and the impact of psychiatrists in the system. VMOs are primarily utilised for direct clinical work and supervision, meaning that other essential duties normally performed by a staff specialist, including research, supervision, training, clinical governance, and leadership, are left undone.

viii: the relationship between NSW Health agencies and medical practitioners

No specific comment.

ix: opportunities for an expanded scope of practice for paramedics, community and allied health workers, nurses and/or midwives

If this is to work effectively it will require a system that is well integrated across all sectors and across the continuum of care, with clear role definitions. If these workers are to accept a higher level of clinical risk, there will be need for well-defined clinical supervision and clinical governance policies. Psychiatrists, as the most extensively trained mental health professionals, are best placed to play a critical role service supervision and governance in such circumstances.

x: the role of multi-disciplinary community health services in meeting current and future demand and reducing pressure on the hospital system

This is essential. The role of the comprehensive Gap Analysis, which has been undertaken, will define the major gaps in community mental health service delivery. It is the opinion of the RANZCP, that investment in critical community services is the most effective and efficient way to reduce pressure on the hospital system.

xi: opportunities and quality of care outcomes in maintaining direct employment arrangements with health workers

The number of psychiatrists in permanent, full-time, or regularly scheduled work has decreased significantly in the NSW mental health sector. Those that are permanently employed are increasingly on part-time, fractionated arrangements. Again, as described above, this has led to reduction in critical care outcomes. Clinical leadership, continuity of care for patients, all suffer with a fractionated, and diminishing, workforce.

According to Psychiatrist Clinical Directors on the frontline of mental health services in NSW, this dangerous combination of under-resourced community mental health services and reduced specialist time, has led to working conditions that are borderline unsafe, particularly at times of leave, when there is very little capacity for effective cover of one consultant by another.

To fill these positions, data from NSW Health shows 50 positions currently filled by locums, at pay-rates that are well over senior VMO award.

We believe this is an untenable collision of circumstances that poses, not only an existential threat to public psychiatry, but compromises the health of frontline workers already experiencing burn-out.

G: Current education and training programs for specialist clinicians and their sustainability to meet future needs, including:

Sustainability depends upon psychiatry being a popular training option. Being popular requires:

- Having a training system that is coherently organised
- Having a training system that is resourced to meet the needs of the (expanding) trainee workforce.
- Having sufficient PGY rotations in psychiatry, which are the single most effective pipeline into psychiatry
- Having affordable Formal Education Courses
- Having competitive salaries and conditions

Formal Education Courses (FECs): there are three in NSW but trainees are able to access other courses, from interstate, on-line. The courses run for the first 3 years of training.

Fees are an issue: in NSW, since 2020, places in the HETI course have been subsidised ($1000 a year). The University of Sydney course is not subsidised, has lost NSW trainees, and relies more on interstate enrolments. The Hunter New England LHD course is for local trainees only and the course is provided free of charge.

There is a review of FECs by the RANZCP, aiming to standardise curriculum.

i: placements

Placements are determined by service demand and specific training requirements. There are compulsory rotations, conducted in Stages 1 and 2 (i.e., the first 4 years of training).

Acute public hospital psychiatry is the main game for LHDs, and service priorities tend to take precedence over subspecialty rotations when there are workforce supply issues.

In terms of distribution, the traditional problems continue, with issues in outer metro areas and regions. As noted, little is done to incentivise training in the bush in NSW.

ii: the way training is offered and overseen (including for internationally trained specialists)

Most training occurs in the public sector. There are three stages, and in the third stage advanced training is possible. FECs are offered in the first two stages. There are mandatory rotations, and barriers to progression can occur due to unavailability of compulsory Child and Consultation Liaison terms.

There are 5 networks in NSW, each comprising urban and rural areas. Training is overseen by 5 Network Directors of Training, as well as Directors of Advanced Training, Site Coordinators of Training, all overseen by Network Governance Committees (NGC's), the Psychiatric State Training Committee, HETI and the RANZCP Branch Training Committee. Standards are set by the College which is responsible for accreditation of placements.

The RANZCP recently commissioned a review of support needs for training administration. There has been a 60% increase in trainees over the last decade, but there has been no change in the level of administrative support. That review, specifically comparing NSW with Victoria (similarly sized jurisdictions), detailed issues in NSW with complex governance arrangements in the interplay between the various stakeholders, and some confusion around College versus Employer responsibilities and reporting. The following is an extract from this internal report:

> *NSW has historically had the highest number of psychiatry trainees of any Australian jurisdiction. There were 632 doctors in psychiatry training in February 2024. In 2005, to manage the high number of trainees and vast geography, NSW Health established a networked arrangement for psychiatry training and provided funding for workforce roles such as Network Directors of Training (DoTs), Directors of Advanced Training (DoATs), Site Coordinators of Training (SCoTs) and some Education Support Officers (ESOs).*
>
> *NSW has five Psychiatry Training Networks, each contains a mix of metropolitan, regional and rural regions. They do not all share geographical boundaries or proximity aligned to one local health district (LHD and training sites in each Network may be over 500 kms apart.).*
>
> *RANZCP funds the Branch Training Committee (BTC) Secretarial Support (SS) roles (1.4 FTE). The BTC Chair is a voluntary role and unfunded, although supported in-kind by the employing LHD. All other jurisdictions fund the BTC SS from Department of Health (DoH) or equivalent sources.*
>
> *Successful operation of the networked training program relies heavily on the ongoing collaboration of several organisations, several committees and numerous roles. These stakeholder roles and responsibilities continually intersect, and some stakeholders have dual reporting lines or accountabilities.*

The DoTs for example report to LHD mental health clinical directors for aspects of their role, to the Network Governance Committee (NGCs) and Psychiatry State Training Council (PSTC) for others, and finally to the College via the BTC on College related responsibilities. LHD Mental Health Clinical Directors chair the NGCs on a rotating basis (rather than the DoTs chairing), which stakeholders' thought was appropriate for the NSW networked model.

- *The key organisations are:*
  - *NSW Health – Health Education and Training Institute (HETI), the Ministry of Health, LHDs and specialty health networks (SHNs). HealthShare is involved in operational functions of the Annual Medical Recruitment (AMR)*
  - *Other organisations – RANZCP (NSW and Bi-national Office) and Formal Education Course (FECs) providers.*
- *The committees are:*
  - *NSW Health led – PSTC and NGC*
  - *College led - NSW BTC.*
- *The main roles are:*
  - *NSW Health funded – DoTs, State Network Directors of Advanced Training (DoATs), DoT, ESOs, DoAT Administrative support, PSTC Chair, HETI Network Coordinator and HETI Network Support Officer*
  - *RANZCP funded - BTC SS Coordinator and SS Officer.*

Historically, NSW had ensured coverage of rural rotations by transferring metropolitan based trainees for 3- or 6-months rotations. The establishment of Networks across urban and rural areas facilitated this.

More recently, due in part to the NSW Health funded RANZCP Rural Psychiatry Programs, promoting and supporting training in rural NSW, there has been an expansion in numbers of trainees living and working in the bush. These now number 50. In Northern NSW this has been further facilitated by the appointment of a Rural Director of Training, using temporary Federal FATES funding, that position now funded in ongoing way by the LHD. Since this position has been in operation there has been a dramatic increase in LHD based trainees. In light of this success, the RANZCP, in its pre-budget submission, called for funding of four rural DOT positions across the State, to further promote the attraction, training and retention of a psychiatric workforce in the bush.

In addition, in the wake of its review, the RANZCP sees the time is now to review the Network arrangements in NSW, as well as the governance structures. These need to be simplified, the State needs to fund the additional administrative requirements that has come with the expanded trainee workforce over the last decade, and the notion of

separate rural networks should be explored, given the evidence of their being self-sustaining.

The other crucial workforce in NSW is the overseas workforce. NSW has a long history of attracting IMGs for trainee and specialist psychiatry posts, notably in Hunter, Wollongong, Western and Southwestern Sydney.

The RANZCP notes the recommendations made in the Independent Kruk Review into Health Practitioner Regulatory Settings (17) to alleviate shortages in the health workforce.

The RANZCP agrees that inefficiencies in the systems should be addressed, but also see the vital role of Specialist Colleges in setting the standard for IMGs and ongoing assessments. The RANZCP will be offering solutions to Government, to ensure its pivotal role as the judge and monitor of appropriate psychiatric standards.

iii: how colleges support and respond to escalating community demand for services

The RANZCP continues to advocate for appropriate levels of funding for mental health services. The College is also advocating for increasing PGY rotations in psychiatry (the single most important factor in recruitment into training). Victoria mandated all PGYs having to do a psychiatry rotation in their pre-vocational years. Although there has been a retraction in this ambition, there are still many more PGY training opportunities in Victoria than NSW, which may account for the significantly increased interest there in psychiatric training. In its 2024-25 NSW Pre-Budget Submission RANZCP called for an increase in PGY psychiatry rotations by 50 per year, for the next 3 years.

The RANZCP is also advocating with the Federal Government for increased funding for rotations in the private sector, in hospitals and private rooms, to improve the range of clinical experiences for trainees, seen as more attractive to potential candidates.

iv: the engagement between medical colleges and local health districts and specialty health networks

See above. This engagement is complex but occurs primarily through the DOTs who work for the LHDs but also have a reporting role to the BTC, and HETI is also represented on the BTC. Obviously, the College monitors supervision and the monitors the fidelity and sustainability of training positions. The RANZCP accredits sites and, rarely, has needed to engage with LHD's when sites are at risk of not meeting accreditation standards. There is increasing concern, due to the senior medical workforce crisis, that sites will be unsustainable, necessitating College intervention in the near future.

v: how barriers to workforce expansion can be addressed to increase the supply, accessibility, and affordability of specialist clinical services in healthcare workers in NSW

Psychiatrists and registrars want to work in systems that are well-led, robust, ethical, where moral injury isn't part of daily work, where their clinical skills and expertise are valued (1, 11). The role of Government in committing to mental health investment and reform is critical in contributing to confidence in the workers in the sector.

As noted above, psychiatry in NSW is less popular as a training option than it is in our main competitors, Victoria and Queensland, and we know (anecdotal advice) that those interested in psychiatry from NSW are moving interstate.

Improved remuneration is one issue, and possibly the sense that a better training experience will be had, in services where there is new investment (and perhaps optimism). There is also the increasingly difficult cost of living issues in Sydney.

There is no single fix to the supply issue, but we have discussed a range of issues, many of which are on the agenda of the State's Psychiatry Workforce Group, including.

- Urgently addressing pay/conditions issues for senior and junior medical staff
- Protected time to pursue supervision, training, research, clinical leadership, service development functions
- Increase PGY terms in psychiatry
- Establishing a Statewide on-call service, removing this onerous responsibility from staff, which is a cause of burn-out and haemorrhaging of staff from the system
- Streamlining international recruitment, with RANZCP remaining critical to maintained standards

H: New models of care and technical and clinical innovations to improve health outcomes for the people of NSW, including but not limited to technical and clinical innovation, changes to scope of practice, workforce innovation, and funding innovation; and

There are many calls for innovation in the mental health space. This is because of the well-aired opinion that the mental health system is 'broken.' The question is, is it broken, or has it just never been funded, or given the governance structures necessary, to deliver the services needed by the people of NSW?

There may be truth in both. Basic clinical services do not have the required funding but there are also ways we could do things better.

We have spoken to the Productivity Commission's recommendations and to the co-commissioning work. Integration (between Federally and State funded services) of triage and assessment functions at a local level would lead to greater efficiencies. As noted in our pre-budget submission 2024, calling for a $200,000 scoping paper:

We propose a next step in that process, with a focus on **access** and **assessment**. Increasing discussion is occurring around the importance of more centralised specialised triage and assessment services, to improve access, minimise duplication, reduce long waiting periods, and to ensure the most comprehensive assessments of those in most need, at the earliest time in their journey. This was discussed at length at the Productivity Commission hearings, and models have been proposed for the child and adolescent sector (18, 19).

We see integration of services as key to solving the access problem. This would involve State and Commonwealth funded triage and assessment services integrating at a district level. The Initial Assessment and Referral Tool (IAR), and journey mapping, should be consistent across LHDs, for example to identify the providers in each LHD of level 1 to 5 services to allocate accountability for providing the required level of service and increase capacity building and community of practice opportunities at the local and State level.

We see the State as being in the best position to influence and drive such a development, but the proposal requires expert scoping and consultation, driven by the State.

I: Any other matters reasonably incidental to a matter referred to in paragraphs A to H, or which the Commissioner believes is reasonably relevant to the inquiry.

It is known that homelessness is a consequence of poor mental health care and an aggravating factor in a person's mental ill-health journey. Spending on essential residential and community mental health services in NSW is well below spending on the same services in other states (20).

This is despite clear evidence that funded community-based services, whether community health centres or clinics, schools or early childhood centres are the most coherent, sustainable, and accessible approach to early intervention and prevention for people with mental illness. A 'whole of government' approach is required to address this critical issue.

If you have any questions or if you would like to discuss any of the details in our submission, please do not hesitate to contact Richard Hensley, the NSW Branch Policy and Advocacy Advisor. Email: Richard.Hensley@ranzcp.org or by phone on (02) 9352-3609.

5. Recommendations

1. The NSW Government urgently complete the Gap Analysis and publish the results

2. The NSW Government introduce mental health specific innovative funding arrangements (e.g., payroll tax surcharge as in Victoria and Queensland, or point of sale surcharge) to provide ongoing revenue to fund mental health services

3. The NSW Government scope and publish novel governance and funding options for the integration of Federal and State MH services

4. The NSW Government urgently address the gap (between NSW and its main competitors) in the pay and conditions of psychiatric and other mental health workforce staff

5. The NSW Government establish a Mental Health Workforce Unit, to scope the workforce needs for the State, and define an action plan to deliver them

6. The NSW Government conduct a review of the trainee Network structure and administrative needs

7. The NSW Government commit to increasing the role and capacity of the Ministry and/or the MH Commission to drive planning, reform and performance in NSW Mental Health system, including the ensured quarantining of Mental Health budgets, and LHD delivery of mental health services and reform.

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